PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
2000-D42

PROVIDER -
St. Luke's Hospital
Bethlehem, PA

DATE OF HEARING-
December 8, 1999

Provider No. 39-0049

vs.

INTERMEDIARY -Blue Cross and Blue Shield Association/Blue Cross of Western Pennsylvania

CASE NO. 95-0577

INDEX

ISSUE:

Was the Health Care Financing Administration's denial of the Provider's request for an exception to the renal dialysis composite rate based on atypical service intensity proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Luke's Hospital ("Provider") is a hospital-based end-stage renal dialysis ("ESRD") facility located in Bethlehem, Pennsylvania. The Health Care Financing Administration ("HCFA") contracted with Blue Cross and Blue Shield Association ("BCBSA") to act as its fiscal intermediary, responsible for dealing with the Provider on behalf of HCFA for the period at issue. BCBSA subcontracted its obligations to Blue Cross of Western Pennsylvania. The estimated Medicare reimbursement effect is approximately $500,000.

By letter dated April 28, 1994, the Provider requested an exception to the prospective payment ESRD rate for routine outpatient maintenance hemodialysis based on atypical service intensity (patient mix).[1] The rate in effect was the January 1, 1991 ESRD composite rate in the amount of $127.98 per treatment. The Provider's request was timely filed within the exception window established by HCFA. The adjustment request was based on the atypically intense dialysis services rendered by the Provider. Due to the Provider's alleged high patient acuity and resulting intense dialysis services, it projected an outpatient hemodialysis cost per treatment for its fiscal year ending June 30, 1994 ("FY 1994 ") of $233.90.

The Provider requested an exception to its composite rate to account only for a portion of its anticipated costs in excess of the composite rate. The Provider requested an exception only for the additional staffing costs resulting from its atypical service intensity. Specifically, the Provider requested an additional $46.43 per treatment in staffing costs which would raise the Provider's rate to $174.41 per treatment.[2]

The Provider's request was voluminous and detailed.[3] The portions of the request that are pertinent to this appeal are:

(1) The narrative text preceding the exhibits which includes a section entitled "Increased Treatment Costs." This section explains that the Provider's increased costs over the years are in significant part due to its continuing increase in staffing costs. This results

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[1] See Provider Exhibit P-1.

[2] Id.

[3] Id.

from the increased acuity of its patient population, which is discussed throughout the narrative.

(2) Exhibit B, which lists the registered nurses ("RNs"), licensed practical nurses ("LPNs"), technicians and administrative staff.

(3) Exhibit C, which provides a comparison of staff full-time equivalents ("FTEs") and salaries.

(4) Exhibit E, which calculates the staff to patient ratio.

(5) Exhibit O, which demonstrates the cost per treatment by dialysis modality and cost year.

(6) Exhibit P, which is a cost analysis for FYs 1990 through 1995, breaking out costs into different cost areas in order to analyze how and why costs differed from year to year.

(7) Exhibit Q, which includes the Provider's as-filed FY 1993 cost report, including (a) Worksheet S-3, reflecting staff FTEs, and (b) Worksheet I-2, reflecting outpatient hemodialysis staff hours of service.

(8) Exhibit W, which includes staff time schedules.

The Intermediary reviewed the Provider's request and recommended granting the full amount of the request. It stated that the Provider submitted adequate documentation to support this request.[4] The Intermediary did not request any additional or further information from the Provider before making its recommendation or forwarding the request to HCFA.

By letter dated June 24, 1994, HCFA denied the Provider's request.[5] HCFA stated:

Inconsistent Cost Report Data

> The Provider's Exhibit O contains cost per treatment (CPT) schedules by modality. On one of these schedules the CPT for hemodialysis maintenance increased by $34.60 (19%) from FY 92 to 94. This increase was never addressed by SLH.

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[4] See Exhibit I-2.

[5] See Exhibit P-2.

> The Provider's exception request is based entirely on the additional staffing costs of $46.43 per treatment (see Exhibit A.) However, we noted significant inconsistencies in documentation supporting salary costs which are described below.
>
> On the FY 93 Supplemental Worksheet I-2, Part II for outpatient maintenance hemodialysis, SLH reported the identical hours of service (37,983) for Registered Nurses, Licensed Practical Nurses, and Technicians. On the same worksheet for FY 94, SLH reported significantly different hours of service. Registered Nurses were allocated 23,146 hours, Licensed Practical Nurses 10,334, and Technicians 2,068. The total direct service hours allocated for FY 93 equals 113,949, and the total for FY 94 is 35,548. The average direct service hours per treatment for FY 93 is 13.32 and 3.95 for FY 94. These amounts were computed by dividing the total direct service hours by the corresponding number of treatments. Further, the unit cost multipliers from the same schedules indicate the following: Registered Nurses for FY 93 - $9.59 and FY 94 - $18.52, Licensed Practical Nurses for FY 93 - $2.89 and FY 94 - $12.50, Technicians for FY 93 - $0.79 and FY 94 - $17.05. Because of these problems with SLH's documentation, we are unable to properly evaluate the provider's request for the additional salary costs.
>
> In accordance with the documentation requirements of section 2725.3E of the Provider Reimbursement Manual, a facility must document any significant increases or decreases in budgeted costs and data compared to actual cost and data reported on the latest filed cost report. Since the provider failed to address the significant changes in its CPT as reported for FY 92 and 93, and FY 93 and 94, the provider was unable to relate its higher costs to its claimed atypical patient mix

The Provider appealed HCFA's denial of the exception request to the Provider Reimbursement Review Board ("Board"). The Provider's filing meets the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider is represented by Leslie Goldsmith, Esquire, of Ober, Kaler, et al. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that HCFA's denial must be reversed because it is based on an inapplicable PRM section. Congress requires that the Secretary of Health and Human Services render a decision on an ESRD exception request within 60 days of submission of the request. 42 U. S.C. § 1395rr(b)(7).

It would contravene the clear language of the statute, as well as congressional intent, to permit the Secretary to continue to develop and add to its decision beyond that 60 day period. Thus, the Secretary through HCFA or the Intermediary is not permitted to develop new bases or grounds for its denial that are not found in the denial letter issued by HCFA within the 60 day period limitation. Accordingly, the appropriateness of HCFA's denial must rest solely on the authority stated by HCFA in its denial letter.

Furthermore, as the United States Supreme Court has stated:

> [A] reviewing court, in dealing with a determination or judgment which an administrative agency alone is authorized to make, must judge the propriety of such action solely by the grounds invoked by the agency. If those grounds are inadequate or improper, the court is powerless to affirm the administrative action by substituting what it considers to be a more adequate or proper basis. To do so would propel the court into the domain which Congress has set aside exclusively for the administrative agency.

S .E. C. v. Chenery Corp., 332 U.S. 194, 196 (1947), quoted in, Mercy Hospital of Miami, Inc. v. Shalala, No. 91-3268, (D.D.C Sept. 13, 1993) "Mercy Hospital".

In Mercy Hospital the court was also faced with an appeal of an ESRD exception request denial for atypical patient mix. Despite the Secretary's arguments, the court found that it could only consider the bases established in the denial letter to determine if the denial was appropriate.[6] The Provider notes that the Mercy Hospital case is strikingly similar to the Provider's case. In Mercy Hospital, HCFA denied the provider's ESRD exception request for atypical patient mix based on a discrepancy in cost figures, including the reporting of two different historical cost figures and a lack of adequate explanation. The historic cost discrepancy was due to an error in the number of treatments originally reported. The Secretary in that case asserted before the district court for the District of Columbia that she was not estopped from addressing deficiencies in the hospital's exception request which she did not address in the exception request denial letter issued by HCFA. The court ruled otherwise. It held that the Secretary was not permitted to review the request further based on the 60 day time limitation imposed by the statute. The court remanded the case to HCFA for the sole and limited purposes of calculating additional reimbursement due the provider based on the court's ruling that the provider's exception request should be granted.

The Provider observes that in this case, HCFA's denial letter cited one authority as the basis of the denial, Provider Reimbursement Manual, HIM-15 ("HCFA Pub. 15-1") § 2725.3E. That section is an invalid basis upon which to deny the Provider's exception request because, on its face, it applies only to

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[6] Id.

a facility seeking to qualify for an exception as an isolated essential facility. The Provider did not seek an exception to its composite rate on this basis. The Provider sought an exception to its composite rate based solely on its atypical patient mix.[7] Consequently, the documentation and other requirements specified in HCFA Pub. 15-1 § 2725.3E do not apply to the Provider's exception request. Thus, HCFA's denial of the Provider's exception request for failing to comply with HCFA Pub. 15-1 § 2725.3E must be reversed.

The Provider asserts that HCFA's denial must be reversed because it is not supported by applicable authority, as discussed immediately above. Thus, the Board need look no further. However, even if the Board does look further and examines the two factual assertions made by HCFA in support of its denial, HCFA's denial must still be reversed because its factual assertions are without any legitimate basis and are inaccurate. HCFA asserted that the Provider's request failed on two documentary grounds. First, the Provider failed to address the 19% increase in costs per treatment between FYs 1992 and 1993. Second, significant differences in FY 1993 and FY 1994 hours of service for RNs, LPNs and technicians resulted in significant inconsistencies in the "average direct service hours per treatment" and the "unit cost multipliers" for FY 1993 versus FY 1994.

The Provider asserts that its request was fully documented and met all the applicable requirements for an exception request. Accordingly, the Provider met its burden and the request should be granted. Regarding the 19% increase in costs, contrary to HCFA's first reason, the Provider did address the increase in costs per treatment between FYs 1992 and 1993 in its exception request. Both the narrative and the data and analysis in the exhibits of the request explain the increase. In a section of the narrative appropriately entitled "Increased Treatment Costs," the Provider stated that "[a] significant part of the dialysis unit[']s increase in treatment costs are a result of the continuing increase in staffing required to care for our acutely-ill patients and the related salary expense."[8] This section of the request provides further explanation of the increase in costs. Furthermore, the Provider segregated its costs into three direct cost categories and seven overhead categories in order to fully examine the differences in these cost categories from FY 1990 through FY 1995. The comparison used actual data for FYs 1990 through 1993, six months of actual data and six months of projected data for FY 1994, and fully projected data for FY 1995.[9] Although the Provider supplied this explanation and documentation explaining why the costs increased, it supplied even more detailed documentation and analysis on the portion of the costs for which it was requesting an exception. The additional staffing costs is supportive of the increased staffing costs.[10]

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[7] See Exhibit P-1.

[8] Exhibit P-1, pp. 7-8.

[9] See Exhibit P-1, p. 357

[10] See Exhibit P-1.

The Provider observes that the purpose behind the request and all of the documentation requested and submitted is to ensure that a provider adequately documents that: (1) the request is for a valid reason, (2) the reason is supported by the facts at that facility, and (3) the costs which form the basis of the request are reasonable, allowable, and related to the valid reason. The Provider's request fully documents that it served an atypical patient population which required more intense direct patient care staff per treatment than the normal ESRD facility. Even HCFA did not challenge this in its denial letter. The Intermediary's statement in its position paper that HCFA remained unconvinced that the Provider served an atypical patient mix is inconsistent with HCFA's denial letter statement and, therefore, cannot be relied on as a basis for HCFA's decision. Furthermore, such an assertion is disingenuous and a mere post-hoc litigating position which cannot be given any consideration or deference. Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 212-13 (1988). Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate. Further, the Provider's request fully and adequately documents that the staffing costs it requested were legitimate and reasonable. HCFA did not challenge this. Accordingly, the Provider met its burden and the request should be granted.

The Provider notes that the second factual reason asserted by HCFA in its denial letter is the inconsistency in the hours of service for the RNs, LPNs and technicians when the FY 1993 data from Worksheet I-2 of the FY 1993 cost report is compared with the FY 1994 data. For FY 1994, six months of actual and six months of projected data were used. A cost report with a Worksheet I-2 had not been filed for FY 1994 at the time the exception request was submitted. HCFA's denial expresses concern that these inconsistencies lead to variances in total direct service hours and unit cost multipliers when FY 1993 and FY 1994 are compared. Thus, HCFA's concern flows entirely from the inconsistency in the hours of service for RNs, LPNs and technicians for the two years. HCFA's denial asserted that due to these inconsistencies, it was unable to properly evaluate the Provider's request for the additional salary costs.[11]

The Provider observes that when the hours for the two years are compared using the as-filed Worksheet I-2 as the source of hours for FY 1993, there is a significant difference in the two years. However, the Provider's submitted Worksheet I-2 in its as-filed FY 1993 cost report contained an inadvertent, but fairly evident, error.[12] As HCFA's denial letter noted, the Provider reported the identical hours, 37,983, of service for RNs, LPNs and technicians on Worksheet I-2 in the FY 1993 cost report.[13] Because the identical number was reported for each category and because it was inconsistent with all other accounting of service hours for these individuals for this year, it was obviously an error. In fact, what the Provider did was report the total staff service hours without breaking them out for each category of employee.

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[11] See Exhibit P-2.

[12] See Exhibit P-1, P. 477

[13] See Exhibit p-2.

The Provider argues that, as the Court ruled in the very similar case of Mercy Hospital, a discrepancy in historic cost data is not a permissible ground upon which to deny an ESRD exception request. The Provider could not correct that discrepancy. It arose from the fact that there was an error in the historical cost data submitted with its previous year's cost report similar to the error in Mercy Hospital. The Provider was required to submit a copy of the as-filed cost report for the previous year. If that cost report contained an error, as the Provider's did, it still had to submit a copy of that cost report. The dispositive factors are that the costs upon which the Provider based the amount of its exception request (1) did not contain that error and (2) were fully documented in its exception request. The correct service hours for FY 1993 were reported and fully documented elsewhere in the request. The comparisons of staffing between FY 1993 and FY 1994 upon which the Provider based its request are found at Exhibit C to the request.[14] These comparisons did not use the erroneous Worksheet I-2 data for FY 1993. Exhibit C to the request reflects FTEs which are easily converted into hours by multiplying each full time equivalent by 2080 hours. The FTEs, or hours, reflected on Exhibit C to the request are supported by Exhibits B and W to the request.[15] The Provider was required to submit the Worksheet I-2 because it was part of its most recently filed cost report. 42 C. F. R. § 413.170(f)(6). However, the Provider supplied and fully documented the correct patient care hours in its request and used the correct hours as the basis of its request. Therefore, the fact that the FY 1993 Worksheet I-2 contained errors is not a valid ground upon which to deny the Provider's request. Significantly, the erroneous numbers on the Worksheet I-2 did not result in any reimbursement impact. They are not used to calculate reimbursement because the Provider is paid on strictly a prospective basis. When the correct data for FY 1993 is used there are no differences between the historic FY 1993 service hours and the projected FY 1994 hours. Since, as HCFA found, it was the discrepancy in these hours that resulted in the inconsistencies with which HCFA was concerned, i.e., the total direct service hours and unit cost multiplier for FY 1993 versus FY 1994, the use of the correct data completely removes those concerns. This may very well be the reason that the Intermediary recommended approving the request. The Intermediary had access to all of the information to which HCFA had access. Since the FY 1993 hours reflected in the filed Worksheet I-2 did not make sense, and the hours as reflected everywhere else on the request did make sense, the Intermediary may have ignored the clearly erroneous number and used the numbers which were further supported by documentation and upon which the Provider based its request. This is consistent with the Intermediary's job in the exception process which is to review the request for allowability and reasonableness. HCFA Pub. 15-1 § 2723.3.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that in its preliminary position paper to the Board, the Provider suggests that the Board must limit its analysis of the denial of the request to HCFA Pub.
15-1 §2723.3E. The Provider correctly portrayed the legal constraints facing a court reviewing an

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[14] See Exhibit P-1, p. 14.

[15] See Exhibit P-1, pp. 13, 534-667.

administrative determination. See, generally, S.E.C. v. Chenery Corp., 332 U.S. 194, 196 (1947); Mercy Hospital of Miami, Inc. v. Donna Shalala, No. 91-3268 (D.D.C Sept. 13, 1993). However, the Board is not a court. As an analysis by the Board remains within the administrative domain of the Department of Health and Human Services, none of the aforementioned limits on review apply. The Board is not constrained by the language of Mercy Hospital. In Mercy Hospital, the United States District Court for the District of Columbia was required to review the propriety of a denial by HCFA of a provider's request for an ESRD rate exception. The provider had submitted a time study of undetermined informational value, and HCFA thus rejected the exception request as having been inadequately supported. On appeal, the Board reversed the denial. Subsequently, the Administrator of HCFA reversed the Board's ruling and reinstated the HCFA decision, reasoning that the provider's documentation in support of the request was insufficient. The provider then sought judicial review. The court in Mercy Hospital articulated the following limits to judicial review of agency decisions:

> In reviewing an agency's decision, the court is confined to considering only those bases actually relied upon by the agency.

This rule incorporates the limits to review defined by the United States Supreme Court in S.E.C. v. Chenery Corp..

The Intermediary argues that the Board is in no way constrained by such limits. The language of Mercy Hospital, merely a more concise version of the language in Chenery Corp., is directed at reviews by the courts. The separation-of-powers concerns addressed in Chenery Corp. are not present when the Board is examining an appeal from a HCFA decision; that is, the process is still intra-agency, not yet in the realm of judicial review. As such, the Board retains the power to review a decision by HCFA in the full context of the applicable section of the Medicare Act.

Further, in order to fulfill its duty to the Secretary of Health and Human Services ("HHS"), the Intermediary argues that the Board is empowered to consider issues on appeal in a much broader context than Mercy Hospital allows a court to consider. According to the Provider Payment Determinations and Appeals Procedures, HCFA Pub. 15-1,Chapter 29, the Board's powers during appeals are as follows:

> The Board shall inquire fully into all of the matters at issue and shall receive into evidence the testimony of witnesses and any documents which are relevant and material to such matters.

HCFA Pub. 15-1, §2925.1 (Emphasis added).

Therefore, given that the Board is not a reviewing court and is entitled by HHS to full inquiry of the issues presented, none of the limiting language Mercy Hospital applies to the Board.

Assuming, arguendo, that the limits outlined by Mercy Hospital did apply in the instant case, the Intermediary notes that the Board is nonetheless afforded a broad scope of review since the denial letter invokes 42 C.F.R. §413.170. The Intermediary concedes that HCFA erroneously cited HCFA Pub 15-1 §2725.3E under which it evaluated the Provider's ESRD rate exception request. That sets out the guidelines for evaluating claims by isolated essential facilities, i.e., those dialysis facilities whose costs are higher than standard due to their geographic isolation or extreme patient dependency. The Provider had not pursued a rate exception as an isolated essential facility.

The Intermediary based its decision on 42 C.F.R. §413.170 and revealed this in its denial letter. In its denial letter, HCFA instructed the Provider that 42 C.F.R. §413.170(h)(2) governed appeals. Section 413.170(h)(2) reads, in relevant part:

> [A] facility that has requested higher payment per treatment in accordance with paragraph (f) of this section may request a review from the intermediary or the PRRB if HCFA has denied the request in whole or in part.

Id.

Strictly, §413.170(h)(2) applies only to decisions made under paragraph (f); therefore, HCFA's application of subparagraph (h)(2) for possible appeals from this denial necessarily means that subparagraph (f) was the basis for its original decision. As such, a reviewing body, if limited by Mercy Hospital, should direct its attention to decision making pursuant to subparagraph (f) of §413.170.

The Intermediary argues that HCFA did not err in denying the Provider's request for an ESRD rate exception since the Provider failed to explain significant cost variances. The Provider maintains that the large, unexplained variances in nursing costs are the result of inadvertent errors surrounding nursing salaries from one year to the next. The Provider further maintains that the Intermediary or HCFA should have alerted the Provider to the mistake.[16] In its letter that began the rate exception request process, the Provider sought relief pursuant to HCFA Pub 15-1 §§2720 and 2725.1 and 42 C.F.R. §405.439(f).[17] HCFA's consideration of this request, as discussed above, was under 42 C.F.R. §413.170(f), which is the ESRD analogue to §405.439(f).

The Intermediary, as HCFA's agent, argues that it does not owe a duty of full substantive review to the Provider. That duty to present the Provider's best case lies with the Provider. When requesting an exception to the ESRD composite rate, a provider must submit to HCFA its most recent completed cost report and whatever statistics, data, and budgetary projections that are needed to determine if the

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[16] See Exhibit 1-4.

[17] See Exhibit I-1.

exception is approvable. 42 C.F.R. §413.170(f)(6). With an exception request, the burden is on a provider to prove that one or more of the 42 C.F.R. §413 criteria are met, and that the excessive costs are justifiable and reasonable. 42 C.F.R. §413.170(f)(5). Here, the Intermediary determined that the appropriate support documents accompanied the Provider's request, and therefore the Intermediary had no cause to return the materials to the Provider for completion. HCFA Pub. 15-1 §2720.2. Since the Intermediary and HCFA collectively have 60 days to complete an evaluation of a request, the Intermediary promptly forwarded the request to HCFA with its approval recommendation. [18]

Similarly, HCFA is not required to manufacture a provider's case. Section 413.170(f)(5) quite clearly explains what is expected of a provider:

> [t]he burden of proof is on the facility to show that one or more of the criteria are met, and that the excessive costs are justifiable under the reasonable cost principles set forth in this part.

Id.

In the instant case, the Provider argues that HCFA could have and should have computed the appropriate figures and derived the explanations for the variances from data located elsewhere within the request. By arguing this, the Provider attempts to impermissibly shift the burden of proof from itself to HCFA, in violation of 42 C.F.R. §413.170(f)(5).

The Intermediary argues that HCFA appropriately evaluated the evidence presented to it by the Provider. HCFA evaluated the supporting documents thoroughly and considered that the Provider's patient mix may be atypical. However, since significant cost variances were presented, yet not explained, the documentation to support the atypical mix argument was not sufficient. Here, HCFA discovered inconsistencies that cast doubt over the accuracy of the Provider's figures. First, the 19% increase in hemodialysis cost per treatment from FY 1992 to FY 1993 was never addressed by the Provider. Second, the service hours for nurses and technicians for FY 1993 were significantly different from those in FY 1994. The more serious discrepancy is the second one in which total service hours decreased by approximately 69% from FY 1993 to FY 1994.

In it preliminary position paper, the Provider argues that the FY 1993 total nurse and technician figure was inadvertently repeated for each of its constituent parts, thus creating an artificially high total for FY 1993. The figures, as presented, were as follows: Registered Nurses (37,983 hours), Licensed Practical Nurses (37,983 hours) and Technicians (37,983 hours). HCFA compared these figures to those provided for FY 1994: RNs (23,146), LPNs (10,334) and Technicians (2,068). The Intermediary notes that explanation was contained in the exception request to explain this discrepancy. The Provider further argues that the correct data is contained elsewhere in the supporting documents.

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[18] See Exhibit 1-2.

While the facts asserted in that statement may be true, the Intermediary argues that the fact remains that HCFA evaluates any completed exception request as is. As discussed above, the burden is on a provider to prove that one or more of the 42 C.F.R. § 413 criteria are met, and that the excessive costs are justifiable and reasonable.

The Intermediary further contends that in order to have an exception request approved in accordance with the regulations, a provider must show HCFA that a clear nexus exists between excessive costs and their alleged cause. The appropriate regulation reads as follows:

> [I]f these excess costs are attributable to factors related to one or more of the criteria in paragraph (g) of this section, the facility may request HCFA to approve an exception to that rate and set a higher prospective payment rate.

42 C.F.R. §413.170(f)(2).

An exception request that does not illuminate this connection cannot be approved. If an excessive cost is related to operational inefficiency (not a 42 C.F.R. §413.170 (g) factor), then no nexus can exist and the request must be denied. 42 C.F.R. §413.170 (f)(2). If an excessive cost may be attributable to a 42 C.F.R. § 413.170 (g) factor, yet no explanation proving this is available, then no nexus exists, and the request must be denied.

The Intermediary notes that given the incredible volume of exception requests HCFA must process every year, it is reasonable to conclude that HCFA has neither the time nor the resources to second-guess a provider's figures. Here, analyzing the information as presented led HCFA to the result that significant variances existed, and that these variances were not explained. HCFA concluded that the Provider did not explain the nexus between its allegedly greater service intensity and its excess costs as required §413.170(f)(2). HCFA's denial rests upon the request's lack of explanation for the differences in the data, not upon the existence or location of the data. In its position paper the Provider cynically and inappropriately chides HCFA for not discovering that the submitted data is not correct and for not dredging the available materials for correct data. To hold HCFA to such a duty is to shift the burden of proof away from the Provider and onto HCFA. Such an outcome could not have been intended by the drafters of the applicable regulations, given how precisely 42 C.F.R. §413.170(f)(5) spells out what is expected of the Provider.

CITATION OF LAW, REGULATIONS & PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395 rr (b)(7)	-	Filing Exception Requests
§ 1395 x (v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R:

§ 405.1835-.1841	-	Board Jurisdiction
§ 405.439 (f)	-	Payments for Covered Outpatient Maintenance Dialysis Treatments
§ 413.	-	Principles of Cost Reimbursement Payment For End - Stage Renal Disease
§ 413.170	-	Payments for Covered Outpatient Maintenance Dialysis Treatments.
§ 413.170(f), et seq.	-	Procedures for Requesting Exceptions to Payment Rates.
§413.170(g)	-	Criteria For Approved Of Exception Requests.
§ 413.170 (h), et seq.	-	Other Appeals

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1:

§ 2720 et seq.	-	General Instructions for Processing Exceptions Under Composite Rate Reimbursement System.
§2723 et seq.	-	Responsibility Of Intermediaries
§ 2724	-	HCFA Central Office Responsibilities
§ 2725 et seq.	-	Specific Instructions For Adjudicating ESRD Exception Request
Chapter 29	-	Provider Payment Determinations and Appeal Procedures
§ 2925.1	-	Conduct Of A Board Hearing

4. Cases:

S.E.C. v. Chenery Corp., 332 U.S. 194, 196, (1947).

Mercy Hospital of Miami, Inc. v. Shalala, No. 91-3268, (D.D.C. Sept. 13, 1993).

Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 212-13 (1988).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the facts, parties contentions, evidence, law, regulations and program instructions finds and concludes that the Provider should have been granted an exception to the renal dialysis composite rate for its atypical service intensity. The Board finds that the Provider timely filed its request, and that the Intermediary approved it. The Board further finds that the request clearly contained a significant error, i.e., 37,983 hours of service each for registered nurses, licensed practical nurses and technicians. HCFA's review identified the error but did no further review of the obvious error. This was a major part of its decision to deny the exception request. HCFA's lack of approporiate review is in violation of HCFA Pub. 15-1
§ 2724 which requires HCFA to properly review all information submitted. Observance of an obvious error and not responding to it is patently wrong and unfair to this Provider. A diligent review of the Provider's exception request appeal would have resulted in a favorable result for the Provider.

The Board notes that HCFA cited HCFA Pub. 15-1 2725.3E to support its denial of an exception regarding atypical patient mix. That section deals with exception requests for isolated essential facilities ("ISOs"). This Provider does not meet the definition of an ISO. Thus, HCFA erred in its conclusion to deny the exception request. The Board further observes that it has authority to "look beyond" HCFA's error and look at the facts and circumstances. It agrees with the Intermediary that the courts' reasoning in the Mercy Hospital cases applies only to judicial review and not to the Board's review.

The Board thus reviewed the exception request and related exhibits and finds them to be correct and adequate. Thus, the Board grants the Provider's request.

DECISION AND ORDER:

The Provider properly filed its exception request with sufficient supporting documentation to grant the exception request. HCFA's denial of the request is reversed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: April 4, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman